MENTAL HEALTH

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EDITOR: R. F. TREDGOLD, M.D., D.P.M.

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Editorial

It is a common habit for the press, and no doubt a very right and proper one, to tell public individuals and bodies (particularly the former) exactly what they should do, and more often exactly why they should not have done what they have done. They do not so often indulge in the luxury of administering encouragement and praise; and indeed the thoughtful reader is left with the feeling that public individuals and bodies (particular the former) must be the most inefficient or unlucky people alive.

It will therefore be a very pleasant change to all but the most rigid traditionalists, if we say that we feel the N.A.M.H. deserves our heartiest congratulations on its recent Annual Conference.

The experiment was there made for the first time of separating all delegates (after the inaugural session) into eight groups, some thirty to fifty strong, to discuss one of four topics which had been outlined by different speakers at the inaugural session; these topics were:

The Child with reference to the Family
The Adolescent with reference to Education
The Adult with reference to Industry
The Aged

and two groups thus were left to study each. At each group there was a leader, invited by the Association, who took the chair. There were also several members of the group who had been designated to be "active", while the others were to be allowed to remain passive. This last suggestion did not work out in practice at all as it had been intended, for some delegates were apparently so shocked by their proposed activity that they did not arrive, and—more important—the great majority of the members of the groups were very easily and readily led to become anything but passive. There was, in fact, a very free and frank discussion of all the problems at issue, and the leaders' only task was to keep their groups within their terms of reference. These discussions were very different from previous conferences, when the conditions of an enormous public hall and a large audience have often effectually prevented constructive and even relevant suggestions, and have led to some frustration in those unable to take part. This year all had a chance to speak, and not once only, and all had a chance to put forward their ideas and criticize each other's; all, moreover, derived something good from meeting those from different surroundings; and even if (as was stated from the platform later) certain professions, such as the medical, came in for some rough handling, this will have done them nothing but good. As a result of two sessions held in this manner, constructive proposals were able to be collected by the group leaders, and these were reported back by them to the main body in the fourth and final session.

It is too early to assess the value of these recommendations, but it is already obvious that this change in the form of the Conference has been very stimulating to all who attended; and that there has been a great deal more information exchanged than in previous years, so that experimental work in one area has been described for the benefit of others. There may be—no doubt are—a few other changes to be made by next year, but we hope the new form of conference has come to stay. And, finally, lest our readers or contemporaries should be too shocked by our lapse into praise, we can reassure both by stepping back on to the familiar ground of infallibility, and remind them that such changes were recommended in this journal two years ago—February 1948 Editorial—and we believe by many of our readers some time before that.

The Editor apologizes for the late appearance of this issue due to vicissitudes beyond his control.

The Progress of Mental Hospitals. II

By W. GORDON MASEFIELD, C.B.E., M.R.C.S., L.R.C.P., D.P.M.

The Introduction of the N.H.S. Act

The transfer of control of mental institutions from local authorities to Regional Hospital Boards has, in most areas, been carried out with little difficulty or friction. In the majority of cases mental hospitals and M.D. institutions of 1,000 beds or more have been given Management Committees of their own, the personnel of which has been drawn from a wide field and in many cases includes a satisfactory medical representative, bringing in a considerable amount of new interest. Where the medical superintendent is himself a member of the Hospital Management Committee his right is ensured to be present at all deliberations concerning his hospital. There are other cases, I think unfortunately, in which even quite large mental hospitals or M.D. institutions are grouped with non-psychiatric hospitals and are under House Committees with very limited powers (and these in some cases grudgingly granted) which involves difficulty in working with duplication of officials, some of whom can have a very limited knowledge of the special needs of a mental hospital, resulting in a general feeling of frustration on the part of the medical superintendent and others concerned. Whatever may be possible or desirable in the future I am quite sure that the administration of a large mental institution in the present period of settling down under the Act must be more efficient under a Management Committee of its own. I would like to make it clear that this opinion is most certainly not aimed at keeping psychiatric hospitals isolated in their work. There are many effective ways of integration given co-operation and goodwill. Among new factors which have arisen is the appointment of regional psychiatrists whose task it is to promote psychiatric developments in the region, to keep in close touch with all mental health activities in the region, to co-operate with all medical superintendents of mental institutions and to act as advisers if called upon but in no way to interfere with day-to-day hospital management. It is also looked upon as important that a regional psychiatrist should continue to do some clinical work, e.g. out-patients. I cannot but think that such appointments have been and will continue to be of great benefit to the mental health service throughout the country and that where such appointments have not been made, a valuable opportunity has been missed of furthering the cause of psychiatry and its service to the public in the area, for of the need of thorough co-ordination of all branches of the specialty in each region I have no doubt whatever. The regional psychiatrist appears to me to form a most useful and welcome link between the medical superintendents and the Regional Hospital Board and also between the various authorities who have statutory responsibilities under the National Health Service Act.

The Medical Staff

Now, what of the relationship between the medical superintendent and the remainder of the medical staff? In the first place the medical establishments now laid down by the Boards show very marked upgrading, in most cases, both in quality (i.e. status) and numbers. In addition to the medical superintendent (who obviously must be of consultant status) in mental hospitals the number of specialists may be of the order of 1 to 300 patients or thereabouts, with corresponding numbers of registrars and house officers, with rather fewer in M.D. institutions—the numbers varying to some extent according to the out-patient clinic commitments and intended expansion. The new factor is, of course, that the medical superintendent is on a similar range of pay to the other senior members of the medical staff. At once the criticism, so often heard in the past, that the service offers prospects and incentives only to the administrator is met completely. I do not wish to dwell on the difficulty which arose when the terms of service regarding the salaries of medical superintendents and deputy medical superintendents were first made public because, with goodwill in interpretation on behalf of Boards and Committees, I believe that the later ministerial pronouncement that " the time given to purely administrative work need not, it is estimated, exceed 10 per cent. of the time given by a whole-time officer and this may properly be regarded as so small a proportion of the time that there need be no abatement of the remuneration at clinical rates for the whole of his time " is, at any rate, for the present a satisfactory

solution regarding our specialty. In the settlement of an awkward situation I am quite sure that we are much indebted, as on numerous other occasions, to the good offices of our friends in the Mental Health Division of the Ministry. The whole incident does, however, act as a warning that the general trend of departmental policy is to belittle the value of medical administration. This is poor acknowledgment of the whole-hearted service given in the past by medical superintendents many of whom have devoted the best years of their lives ungrudgingly to the interest of the patients and staff of their hospitals. It is insufficiently recognized to what a great extent the hospital has been not only the source and inspiration of the work but also the focus of the hobbies and recreation of the superintendent. It is evident and right that now the senior medical staff must not only be granted real clinical freedom but also must feel that they have such freedom (and so abolish those lurking frustrations) in regard to the treatment of the cases under their care. I do, however, suggest that frequent meetings of the internal Hospital Medical Committee with frank and open discussion, are the means of smoothing away difficulties that may arise. Here newer, and indeed all, methods of treatment can be freely debated and the results critically considered. The prohibition by a bigoted superintendent of some well-recognized form of treatment can no longer occur and ill-judged experimental methods of treatment can be checked. Here also points regarding the discharge of patients should come under consideration although obviously (in the present state of the Law) the medical superintendent being " the person to whom any order of detention is addressed " must have the final medical decision. The question as to the extent to which the superintendent should undertake responsibility for beds is one about which there can be no standardization. My personal view is that he should have a limited number under his immediate control—in different parts of the hospital at different times—and that the senior registrar might be specially detailed for the routine duties in connection with such beds. The essential thing is that the superintendent should keep up his standard of clinical knowledge and treatment and that he should take a leading share in the training and teaching of the more junior medical staff, taking an active part, with his colleagues, in any regional scheme for post-graduate psychiatric training, and stimulate by his own example the work of the senior clinicians. In any case the one thing that is necessary is for the medical staff to share the team spirit. Equal opportunity for the sharing of the work of the out-patient clinics among the specialist staff must be afforded as also should be the opportunity for undertaking domiciliary consultations in response to requests by general practitioners. As an important part of efficient medical administration Management Committees and medical superintendents should not lose sight of the present opportunity of obtaining a really satisfactory system of visiting consultant sessions. The status of large mental hospitals must surely be raised by regular and *not* spasmodic visits by general physicians, surgeons, E.N.T. surgeons, gynaecologists, neurologists, pathologists, radiologists, ophthalmic surgeons, neuro-surgeons, in addition to dental surgeons and, more particularly for M.D. institutions, orthopaedic surgeons and paediatricians. The details of these consultant sessions must be arranged through the Regional Hospital Board but the Board is liable to make an estimate of the efficiency of the work of the hospital by its demands.

Superintendent and Management Committees

This brings me to the relationship of the Superintendent to the Management Committee and particularly to his chairman. I believe that Management Committees appreciate very fully the value of good medical administration and realize the medical superintendent's special position as chief officer which necessitates his exercising a general control over all departments of the hospital or institution —the chairman in particular looking to the medical superintendent for advice in all matters of policy. This is a traditional position which in the peculiar situation of hospital and community life in a mental institution has worked remarkably well and although, under the new conditions, another officer has been upgraded to the position of secretary and finance officer, I see no reason for the relationship, given goodwill on all sides, to be materially changed. I believe that the importance of mutual faith and confidence between the chairman of the committee and the medical superintendent can hardly be exaggerated and that failure in this respect leads to disaster. It would be idle to deny that awkward situations may arise between lay secretaries and medical superintendents. Unfortunately, and strangely, some members of the (Lay) Institute of Hospital Administrators appear to have a fixed idea that because a man

has a medical upbringing and qualification he cannot be an efficient administrator whilst, on the other hand, some medical superintendents go out of their way to belittle and ignore the value and importance of the many-sided work of secretaries and finance officers. The position is by no means easy but I believe that, even in those cases where most difficulty has arisen, following really frank discussion, a mutually satisfactory understanding may and indeed should be reached. A great deal of most excellent work has been performed by the Clerks and Stewards Association and latterly the Institute of Hospital Administrators in laying down standards and organizing examinations for those who aspire to the posts of responsibility in the Clerical, Secretarial, Accountancy and Supplies Departments of mental hospitals. In all these the work has year by year become more onerous and responsible and certainly much more so since the appointed day. We must all be pleased that the posts have been upgraded and the status raised—and we must consider ourselves fortunate in the fact that the secretaries of our Hospital Management Committees are men who have years of experience of mental hospital administration.

The need for a Medical Superintendent

I personally am convinced of the need and value of a medical superintendent in a mental hospital in which both short-term and long-term patients are under care and treatment, the institution being at one and the same time an acute hospital, a hospital for chronic sick and a convalescent and rehabilitation centre. No general hospital has all these functions and I am extremely doubtful if any useful purpose is served by attempting to copy too slavishly the methods of administration of general hospitals. An understanding of complex human relationships is more important than an expert knowledge of economics for the medical superintendent who, in addition to his present statutory duties, is a senior consultant with a reasonable share of clinical responsibility and who also exercises a general administrative control of the hospital departments. It has, I think, been well said that administration of a large mental hospital is an example of group psychotherapy on a large scale. A co-ordinator is required in order to preserve harmony and balance. I am, however, of the opinion that the time has come for many medical superintendents to grant a still greater degree of autonomy to heads of departments. Is it not possible that in the past some have failed, for example, to give to the matron of the hospital the status and authority to which she is entitled? In this respect, at least, I think we can more nearly copy general hospitals to the advantage of mental nursing as a whole. I venture to suggest that revision and refresher classes both in the wards and classroom for the senior members of the nursing staff might be more often organized by the matron if she had the encouragement and assistance of the medical superintendent. It is, of course, important that the matron (and the chief male nurse) should have the opportunity of being present at all committee meetings at which matters concerning their departments are under discussion. This has not been, in my experience, by any means the usual practice although it has been customary for the engineer to be present at the Works Sub-Committee and for the farm bailiff (or manager) at the Farm or Estates Sub-Committee. The wise delegation of duties and the sharing of responsibilities are most certainly marks of good administration and do not, in the least, lower the prestige of one holding the position of medical superintendent. It seems to me that the headmastership of a large Public School is perhaps the best form of analogy to the post we are considering, and I do not recall that any serious suggestion has ever been made that the head of any Public School should be other than a schoolmaster—and yet we have to face the criticism that there is something out of date (or even improper) in the administrative head of a mental hospital being a psychiatrist! The alternative, of course, is that there should be a lay superintendent—presumably called a house governor—as chief administrative officer and that the statutory duties (which cannot be avoided) should be carried out by a medical officer of lower grade. Can anyone with experience of mental institutions believe that this would be in the interests of the patients and of the mental health service? Is it at all times and in all places remembered and recognized that the welfare of patients must be placed first? Many questions arise touching their treatment, admission or discharge, concerning their relatives, the medical staffing and medical equipment, etc., which require replies or decisions at short notice and which cannot wait to be referred to a Hospital Medical Committee. Under a lay superintendent such questions would have to be dealt with by himself without medical knowledge or by an inexperienced

medical officer without true authority. It is, perhaps, more particularly in considering the future developments and extensions of the scope of a hospital that the views of an experienced medical superintendent are essential for his committee. The fact that there is so little or no difficulty in obtaining the admission of a patient to a mental hospital when required at short notice, at any hour, is in itself a tribute to sound administration and absence of "red tape"—and it is in direct contrast to the serious difficulties sometimes encountered when an urgent surgical or medical bed is required in a general hospital—the difference being that, quite frequently, in the latter case a member of the staff of junior rank is permitted to say that there is no bed available. The opponents of medical administration find it extremely difficult to accept the fact of a medical superintendent being granted full consultant status and pay, and at the same time holding the position of chief officer whilst only a tenth of his normal working hours is devoted to purely administrative work. It is, therefore, quite evident that every medical superintendent should give thorough consideration to the position and, in complete co-operation with his chairman and committee, formulate a plan bringing all senior members of his staff into the picture which will show clearly that the administration of the hospital is in step with the trends of the times.

I cannot treat seriously the suggestion that a medical superintendent should have the option of a part-time appointment if he so wishes which would involve non-residence at the hospital. I am of the opinion that, when there is a satisfactory complement of registrars and house officers in residence, the only one member of the specialist staff who must of necessity live on the estate is the medical superintendent. I, personally, am anxious to see the experiment tried of some part-time psychiatric consultants. I believe that it might, so to speak, bring a breath of fresh air into the hospital for at least one or two of the psychiatric consultant staff to have sessional commitments in other hospitals, in clinics in other areas or even to be engaged in private practice. I welcome any such plan which may tend to destroy the lingering distinction between institutional and non-institutional psychiatrists—which is one of the things that must be broken down. But for a medical superintendent I cannot but feel that the welfare and interests of his hospital and the extension and upgrading of its service to the public involving many and varied extra-mural commitments must demand his wholetime energy and loyalty. The question must now be faced as to whether, in the future, suitable applicants are likely to come forward to fill the posts of retiring medical superintendents. Is there sufficient inducement, under present conditions, for the well-qualified, experienced clinician with the right type of personality to wish to undertake the responsibilities involved? I have, however, great faith in the present generation of psychiatrists who are now eligible for such posts. They returned from their war service years with a wider outlook on psychiatry and its future than they could have obtained otherwise and I look with confidence to them to carry on the succession of medical superintendents. To guide the destinies and fortunes of a psychiatric hospital, to help it to contribute its proper share to the mental health service of the region, to act as the democratic leader of a team of experts and to be the spokesman of his colleagues in a wide field is surely a worthwhile prospect for a keen and progressive psychiatrist and will surely carry its own rewards. It is a great step forward that, under the National Health Service Act, medical superintendents, recruited from the rank of specialists, are now appointed by a specially convened Advisory Appointments Committee, the personnel of which guarantees that no hasty or unwise choice can be made. As regards the post of deputy medical superintendent, I feel that, under present arrangements, perhaps the most equitable and suitable plan would be for those of specialist status to act for or on behalf of the superintendent when absent for an agreed period on a rota basis. This, it appears, is the only way in which the senior psychiatrists can have an opportunity of determining whether the responsibilities of medical administration have any attraction for them—and, at the same time, disposes of what, I think, is an unfortunate position, i.e. a man holding the post of deputy medical superintendent for an indefinite number of years.

The Future

As regards the future I wish to emphasize the crying need for the modernization and simplification of the law as regards the admission to mental hospitals. The Mental Treatment Act 1930, was a great step forward in that it permitted patients to be admitted to mental hospitals on their own written request (resulting now in some 60-80 per cent. being admitted thus) and for those who by reason of mental illness are

incapable of expressing willingness or unwillingness to receive in-patient treatment a form of temporary treatment, i.e. for six months without judicial intervention on two medical recommendations (resulting in some 10-12 per cent. on this basis). But certainly the most urgent and progressive further legislative step is for all patients, suffering from mental illness, who are not suitable for voluntary treatment to be admitted as temporary patients and so, once and for all, remove the out-of-date magisterial intervention, i.e. the reception order, and make admission in the first place a purely medical matter. It is probable that it may be necessary to retain the certifying procedure for cases which show no appreciable improvement after (say) two years in-patient treatment. The task of signing reception orders is not one which J.P.s welcome, and the job of writing medical certificates indicating that a person is of unsound mind is thoroughly unpopular with general practitioners—and may, I venture to say, not at all times performed very well. At one time I made something of a collection of examples of medical certificates which I thought would have been better if worded somewhat differently or which contained gems of unconscious humour. May I cite the following: (1) " He is abusive and delusional. He says I am a damned fool (which is not so)." (2) " These facts are known to be untrue." (3) " He has to be washed and shaved like a baby." (4) " She has most grandiose ideas, e.g. she thinks she is to be married to a doctor." (5) " He has been a deficient all his life. He knows nothing. He has no brain." Whilst speaking of general practitioners, it would be an excellent thing if they could sometimes find time to visit mental hospitals and see their patients under treatment, to see the methods adopted and to discuss the cases on the spot. A first-hand report to the relatives of the patient by the family physician means so much. It would also be a stimulus if divisional clinical meetings of the B.M.A. were held periodically in mental hospitals—which now in reality have an atmosphere of active treatment and hopefulness in contrast to the somewhat depressing chances of cure of some years ago. It is unfortunate that we must look farther into the future for any substantial building programme for mental hospitals. There is no doubt that, speaking generally, many are working under a severe handicap owing to the out-of-date buildings which were planned for custodial care and detention. The most modern type of psychiatric hospital is planned entirely on the villa or separate unit system. In the centre is the administrative building without any wards for patients and surrounding it, at varying distances, are admission, convalescent, disturbed and excited, epileptic, senile, long-term or chronic, sick infirmary (with operating theatre) and " parole " units, each maintaining its own identity with its own garden and avoiding all risk of disturbance by or to others.

Here we must leave the story of mental hospitals. Changes have inevitably and rightly come about. I believe that they are in the natural and beneficial order of events and to come under the general heading of evolution. This process must go on—with the co-operation of us all. Psychiatry began with custodial care for those severely incapacitated because of mental illness and up to the last century, as we have seen, its progress consisted chiefly in humanizing this care. The next step was to reach a better understanding of the nature of mental disturbance and so to develop curative measures. Now we must concern ourselves not only with treatment but also with prevention. This is essentially a social problem of education and enlightenment of the public and of all types of social worker—in this we can all take a share.

It is in the nature of things, it is in the nature of human personality and of the development of life as we know it, that the highest values of civilization can only be maintained if we are prepared to treat human personality as of the utmost importance and always, so far as in us lies . . . to keep the ideal that people shall be treated as ends and not as means. There, I think, is the great opportunity for psychiatry.

WALTER RUSSELL BRAIN in address at N.A.M.H. Conference.

The Child's Need for Identification

By M. H. HOLMES

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If one could ask what one wishes most for the future of a child it is, perhaps, that he should grow up into an integrated personality. A mature adult has, in childhood, built into, or integrated into himself, all the " growing-up " processes, and he could only achieve this by identification with the adult, since a good identification is the basis of maturity.

Before a child can make a good relationship with an adult he must feel secure, and real security is difficult to achieve without the basic oneness of the very early mother-baby relationship. From this emerges the capacity for relationship with other loved adults, and the need to copy them—partly, it would seem, because they are loved and loving, and partly because they are so powerful, and the child wishes to take into himself the power of controlling outside forces.

The need to copy the adult is so imperative, however, that even without secure foundations the child will copy any chance individuals, and, it would seem, their chance actions. Perhaps this is best illustrated by reference to a Residential Nursery, where various adults come and go in the child's life. I have watched children of two putting their hands under their frocks to open the bathroom door, just as the nurses used their hands under their aprons when their hands were wet. " Sister " wore a dark blue band round the waist of her uniform; a little girl of three was seen wearing a dark blue band of paper round her middle, saying, " I'm Sister." The children would often play the nurse's role as headwasher, saying while vigorously rubbing another child's head, " Don't cry, now. I won't hurt you. There, it's all finished."

Johnny, at three years, had scarcely spoken, but when he did it was to mimic the exact tone and words used to him: " Johnny, do as you're told *at once* ", " Hang up your towel, *do*, John ". In this way the children overcame their fear by acting and talking like the all-powerful adults.

Sometimes it was not only this desire to be as strong as the adult which led to identification, but also the desire to be as helpful and as constructive. David (3½) was found sitting on the floor with a soft toy elephant out of which the stuffing was coming, using the tag end of a coloured bead-threading lace, completely absorbed in trying to sew the doll together again as he had seen the adult do. I had given Vera (4) a doll for her birthday and explained that she should keep it in her bedside bag as her very own doll. Later that morning she brought me the largest doll from the toy cupboard, saying, " Here you are, Miss H. Here's your very own doll to keep in *your* bag."

A child seems to gain reassurance out of identification. Matthew was often heard saying to himself reflected in the looking-glass, " Good boy, Matthew Nalan ", while Kate, having had her forehead stroked at resting time, continued to do this to herself when the adult stopped. That the process of identification can work in the opposite direction was, however, shown by David. He had been going through a difficult phase and had constantly heard how naughty he was. One evening he was found sitting despondently on the stairs saying over and over to himself, " I'm getting a very naughty boy ".

Sometimes, in order to overcome temporarily his feeling of smallness and powerlessness, the child needs to reverse the roles of child and adult. I would often finish a request to Mary (4½) with " There's a good girl, Mary ". One day I asked her to take her comb indoors just as she had started dressing her doll, and she said, " *You* take it in, there's a good girl, Miss H. I'm busy."

Some residential children seem to make a good and apparently normal identification, but it is doubtful how far they integrate it. They have often missed the completeness of the mother-baby relationship, they miss, too, the consistency and affection of parental handling. This lack of an identification pattern in residential homes accentuates other symptoms of immaturity. The child at home overcomes his fear of father by swaggering after him, hands in pocket, by being temporarily a miniature father. The little girl cares for her doll as mother cares for baby, and so overcomes her feeling of helplessness and envy. The residential nursery child, unable to identify with one

secure adult, is forced to master his fear by going to any lengths to master the adult by annoying her. At four years, Jim said to Nurse, " I will sniff till I make you feel sick ", and constantly when asked to give up something he had, a child would dance defiantly in front of the adult, waving the article in her face, then fling it down on the ground or into the bushes, and watch maliciously while she picked it up. Lack of opportunity to copy the good adult accounts, one would imagine, for the excessive cruelty shown by residential children. Mary (4½), on the point of seizing another child's toy, was overheard to say to Vera (4), " You just watch him cry when I take it away ".

Behind the normal façade shown by the older institution child, is often the need to regress, which emerges so frequently in the security of a foster home. While all young children regress at times, residential children regress much more severely. When crossed in any way a despairing rocking of the body often took the place of an aggressive outburst. During the rocking the child seemed completely detached from the adult and his surroundings; one saw in the child's face neither fear nor anger, only a complete isolation and despair. The frustration, too great to be accepted or defied, seemed to drive him into a narcissistic detachment. One child (3½) after getting up from mid-day sleep would nearly always cry helplessly and without being able to accept comfort; after a while she would sink into an absorbed body-rocking. Once when seven children (3-5 years) had taken off their new Wellington boots in order to fill them with water from the garden tap, and so were unable to go out for a walk with the others, they all seven, after crying and temper outbursts, relapsed into rocking on the floor, from which they were with difficulty persuaded to paint.

The residential child's desire to seize and possess the adult's property is perhaps also a compensation for the inability to acquire the adult by identification. Handkerchiefs would be seized subtly from the adult's overall pocket, used and treasured by the child; a brooch, a belt or even a hairclip would be taken surreptitiously from the adult wearer, and were often found clutched in the children's hands at rest time. In the early stages of eating with the children, the adult only had to turn her head to have a potato or a piece of meat seized from her plate. It is as if the insecure child is constantly at watch to get the better of, and to possess something belonging to, the adult.

Because of the lack of a loved adult whom they can copy, residential children build up the ideal picture of a mother. The children wove phantasies about non-existent parents, and Mary (4½), when asked not to do a thing, would say, " My Mummy would let me do it."

The child with his own parents bases his Super-ego on the identification with them. He takes into himself the precepts of father and mother, and becomes selfish or unselfish, sincere or insincere, tolerant or intolerant, both to himself and others, in proportion as his parents have shown these traits. If his parents have done their job even tolerably well, he will be able to extend these identifications, and integrate into his character structure the training and example of teachers, leaders and heroes.

For such identification and character training to be effective, it must, however, be assimilated into the character, not just superimposed, and when the parents are too harsh or too lax, or when the child lives in an institution, this is often not possible. The child needs first to know that the adult is a constant factor; when handled by a number of different people, he is seeking always to make new identifications, and so becomes readily suggestible, with no consistency of character. If the regime is harsh or compelling, though the child may make temporary identifications, he often rejects the harshness, and becomes the eternal rebel. If he accepts the adult's teaching it is often only a superficial acceptance: he adopts habits of tidiness, politeness and obedience, because he has not dared to try, or has not known, the opposite, but he lacks initiative and independence, and is too colourless to become a full personality.

At the best, the residential child is for ever striving by his identifications to overcome the powerfulness of the numerous adults. In order to compensate for lack in the early years it is necessary to give the child as much love and security as possible before a good identification and a toleration of frustration can be expected. Only by boarding out, or by the small family group within the residential institution, can the insistent need for identification be met by tolerant and consistent handling. In this way the child may be able to identify with the parent substitute, and progress towards a constructive and loving identification and maturity.

Mentally Defective Children with Additional Handicaps

By EILEEN FLETCHER

The Fountain Hospital in London, for Mentally Defective Children, has just completed an interesting Pilot Scheme for children with additional handicaps.

In a large institution it is easy for such children to be overlooked and classed as ineducable, merely because their handicaps prevent them fitting into the pattern of the ordinary Occupation Centre.

Twelve children, seven boys and five girls, with an age range from 6½ to 15 years and I.Q.s ranging from 87 to 31, were selected by the Medical Officer and the Psychologist, and a special teacher was engaged for them on three afternoons a week for a period of three months.

The group consisted of five children with cerebral palsy (two from rhesus incompatibility) of whom three had gross deafness and no speech, one had no deafness but very little speech, which was of poor quality and almost unintelligible; the fifth was normal in hearing and had some speech but could not walk. Two walked normally, one could attempt to walk with a shuffling gait if supported, and one could move about well, but had gross inco-ordination.

Of the seven remaining, three had suffered from gross deafness from a very early age and were completely silent, one had slight hearing and could repeat single words but otherwise had no speech. One had considerable deafness and very defective speech which was extremely difficult to follow, one had considerable deafness and no speech, and one had almost normal hearing but an obscure form of aphasia, completely omitting all consonants. Two were also illegitimate and all were mentally defective.

The handicaps were distributed as follows:

A. Deaf. Speech defective and very difficult to follow.
B. Kernicterus (rhesus incompatibility). Deaf. No speech. Gross inco-ordination. Athetosis.
C. An unusual form of aphasia.
D. Considerable deafness. No speech.
E. Deaf mute, very inhibited.
F. Almost completely deaf, no speech. Illegitimate.
G. Kernicterus (rhesus incompatibility). Deaf, no speech, little rapport.
H. Gross deafness. No speech.
I. Some hearing, repeats isolated words. Illegitimate.
J. Cerebral palsy. Deaf. No speech.
K. Cerebral palsy, limited but good speech, no use of legs.
L. Cerebral palsy, very little speech and of poor quality, but hearing apparently normal.

The experiment had three objects in view:

(1) To see if the deafness handicap could be sufficiently overcome to enable the mental defect to be reassessed, in which case it might be possible for some of the children to be rated high enough to go to a Special School.
(2) To evolve some form of education which would enable all the children to enjoy a fuller life.
(3) To encourage them to work together as a group to see if they could derive some comfort and benefit from each other's company.

None of the children had previously worked in a group with others of similar handicap. They were scattered in the various classes of the Occupation Centre and occupied different wards in the Hospital for sleeping and eating.

Almost from the beginning they showed signs of enjoying each other's company, and took a real interest and pleasure in each other's prowess. A remarkable feature of the experiment has been the spontaneous help they have given each other. For example, those who hear, try hard to explain to those who don't, and the deaf are most helpful to those who cannot walk. They are extremely patient with the one who has gross inco-ordination, and in games requiring finger manipulation (which is difficult for him) never attempt to play out of turn, or to leave him out.

As regards speech and understanding, four have made a really marked improvement, including two with whom previously there was very little contact at all.

A vocabulary of nearly fifty words has been built up. All four carry out, and also give, simple commands, they act simple stories which the teacher reads, and use short sentences to describe scenes in their picture books. They can count up to ten, and in the Pre-Reading Exercises can match words and pictures on fifteen cards. They recognize the written names of all the children in the class and can give the name cards out to the right owners.

Five others have made a slight improvement, one of them would have gone further but for a behaviour problem which made it impossible to keep him in the group, and three have made no progress at all. These three are reported as not benefiting from the Occupation Centre so that the lack of progress is probably due to mental disability rather than deafness. Even these three, however, have become much more interested than formerly.

Backwardness in Speech Development

By SUSANNE LIEBMANN, Ph.D. (Berlin)

Apart from the standard exercises used for teaching deaf children tongue and lip movement, all the exercises were specially devised by the teacher for these particular children.

They had to be short, for mentally defective children have little power of concentration and the deafness handicap made them tire easily.

Each exercise had to involve some definite achievement which the children could themselves realize and by which their self-importance could be built up and their personality developed, as their handicaps caused a feeling of inferiority which had to be overcome before real progress could be made.

These exercises, moreover, had to be related to things of which the children had knowledge. This was a particular difficulty, as many of them had been institutionalized for some years. Pictures and objects were used and games built round them which involved plenty of action. Each exercise, therefore, was a source of pleasure to the children, who soon delighted in their achievements.

Even such a short experiment appears to have afforded sufficient evidence to justify the formation of special classes for children with additional handicaps, and the deaf and dumb and the spastic appear to be well suited to a joint scheme.

Some children begin to talk earlier than others. Boys are frequently slower in their development than girls, the eldest child has a tendency to begin to speak later than his younger brothers and sisters.

The fact that a child is still mute at two years of age is often considered as unimportant. So it might be, as in some cases the future development will be normal in spite of this initial backwardness. But there are patients who are handicapped severely by the fact that they did not begin to speak at the normal time; they might be of average intelligence at the age of two years, but due to the lack of stimuli they develop into low-grade defectives.

Children who are not sufficiently talked to, do not learn to speak.*

If a child is not provided with the normal stimuli the development of his nervous system will suffer, and it will be exceedingly difficult or impossible to make up for it later.

The three following examples concern children who were certified as mental defectives and who in all probability would have been classified as such all their lives, but who improved greatly by early training so that two of them could later be discharged from the institution.

A.B. is a girl who was diagnosed as a hydrocephalic. At the age of 3 years 7 months she did not perform any of the test items† and only said a few words. When she was 4 years 8 months old her mental age was 2 years 7 months and her I.Q. 55%. A year later her mental age was 3 years 7 months and her I.Q. 63%. The child has been having special training for roughly two years. Now she is a lively child who talks freely and understands what is said to her.

** I saw a home to which babies were frequently admitted soon after birth. There was enough staff to look after the physical needs of the children but nothing was done to develop their minds. As a consequence many of the children spoke badly or not at all. A girl who was admitted to this institution at the age of approximately two years and stayed there for six months, was mute when she went home though she had been able to speak normally according to her age at admission.*

† The test used in all cases described is the Terman-Merrill test.

C.D., another girl, was admitted to the institution at the age of 3 years, and discharged at the age of 7 years 4 months. On admission she was unable to name common objects and spoke only in monosyllables. When she was 5 years 3 months old her mental age was 4 years 4 months and her I.Q. 83%. She learned to speak very well and she has been attending a Special School for the last four years.

E.F. is a boy who was diagnosed as a hydrocephalic. It was impossible to assess his mental age when he was 3 years 10 months old, as he failed to perform four of the test items of the 2 years' level. A year later his mental age was 3 years 9 months and his I.Q. 78%. At admission his age was 3 years 10 months; he was unable to walk unaided more than a few steps, he said a few words only and understood very little of what was said to him. At the time of discharge at the age of 5 years 1 month (only 1 year and 3 months after admission) he speaks well in sentences, his vocabulary is almost up to his age standard; he walks, and is able to run. Treatment helped the child to develop so that he was accepted in a home for normal children.

There is no question that all these children would not have learned to speak without special treatment. If treatment had started when the children were still younger they might even have developed to a higher standard.

These examples, the number of which could be increased, show that the fact that a child appears to be very backward does not prove that he is or will be a mental defective.

Therefore, early treatment* should be given to almost every child who does not begin to speak at 2 years of age. If he has special training early, many a child certified as a mental defective might have developed to be a normal citizen or have been trained to do useful work instead of having to be cared for all his life and to be absolutely useless.

An important question is the surroundings of the patient while in training. Special nurseries should be provided for them under the care of persons who have the necessary time and ability to assist in their education. These young children should not be kept in the same wards with older defectives and with those who do not respond to treatment.

The statement " once a mental defective always a mental defective " is a very dangerous one. If a child has a low I.Q. at 3 years of age and even later, he may be a normal child who was only starved of stimuli. We should always give him the benefit of the doubt. The criterion whether a child is a mental defective or not, should be whether he responds to skilled treatment in adequate surroundings; only if he fails to do so should he be described as a mental defective.

Convalescence for the Elderly Patient

Dr. Marjorie Warren, Physician in Charge of the West Middlesex Hospital's Geriatric Unit, was able to use accommodation offered to her by the National Association for Mental Health in its Holiday Home at Bognor for some weeks during the winter months. She has kindly contributed this report of the experiment which draws attention to an urgent need.

One of the problems connected with the care of elderly patients is that of ensuring that once recovery from illness has been achieved the patient's condition does not deteriorate again as a result of inadequate social after-care. Many elderly patients have difficult home conditions, they are frequently living alone, and for some such patients a period in a recuperative home immediately after their discharge from hospital is very desirable. Others are living with relatives who find the constant presence in the home of a person of an older generation a considerable emotional strain, and it is important (quite apart from any reason connected with physical well-being) to be able to remove such patients from their home surroundings occasionally in order to provide them with new interests and in order to give the relatives some respite from this strain. Unfortunately, the number of vacancies available in convalescent or holiday homes is very limited for elderly patients, as most homes impose an upper age limit of 65 years.

We were particularly grateful, therefore, to be given the opportunity of " borrowing " the " Old Vicarage " at Bognor for two months in

* *Treatment was given according to the method and with the material of Albert Liebmann, M.D., as described in " Untersuchung und Behandlung geistig zurueckgebliebener Kinder ", second edition, Berlin, 1920 (Examination and Treatment of Mental Defective and Backward Children).*

order to use it exclusively for patients from the geriatric wards, and we were very fortunate in having the co-operation of the Middlesex County Council in assisting with the financial aspect of this experiment.

Most of the patients who went were in their late seventies. Eight were sent—five women and three men—with the idea that they should be replaced at the end of the first month by another eight. In fact, however, some of the first party remained for the full two months.

The people who went were mostly out-patients who had been known to the staff of the geriatric unit for a considerable time, and, while the winter does not seem on first thoughts the best time in which to arrange recuperative holidays for elderly people, this scheme had the great advantage of removing them from their homes during the time of year when it was particularly difficult for them to manage. Carrying coal and wood, cleaning fireplaces and shopping in bad weather are major problems to elderly people.

The experiment was a big adventure to many of the patients, and the great physical improvement and alteration in mental outlook achieved after a few weeks of warmth, regular meals and comfort was most impressive. One man who went to the "Old Vicarage" direct from the ward was particularly outstanding. He had been admitted to hospital as an emergency case, and when he came in was saying that he "would do himself in" as he felt so miserable and his home conditions were so difficult now that he was not well. After a period in hospital followed by two months at Bognor he was physically capable and mentally eager to live an active life at home again.

Members of the staff of the geriatric unit visited the "Old Vicarage" on various occasions, and were particularly impressed not only by the high standard of comfort and care the patients were enjoying, but also by the understanding that was shown of the problems and personalities of the elderly.

News and Notes

London's Mental Health Service

Mental Illness

During 1949—we learn from the current Report of the L.C.C.'s Chief Medical Officer of Health (Sir Allen Daley)—6,964 patients were dealt with by the mental welfare department under the Lunacy and Mental Treatment Acts, of which number 5,326 were admitted to hospitals for observation under Section 20 of the Lunacy Act; 2,210 of these were subsequently certified and transferred to mental hospitals; 120 persons suffering from some form of mental illness were provided with "recuperative holidays" in Homes of the Mental After-Care Association—23 after treatment in general hospitals, 17 after treatment in psychiatric out-patient clinics and 72 on leaving mental hospitals.

An After-Care Service provided jointly by the Mental After Care Association and the National Association for Mental Health was inaugurated on May 1st, 1949, for which the Council agreed to provide 90 per cent. of the cost. Under this scheme, 282 patients were visited by the National Association and 185 by the Mental After-Care Association.

The Council also agreed to contribute 90 per cent. of the cost incurred by the Institute of Social Psychiatry in opening a sixth Therapeutic Club and an occupation centre for rehabilitation open to various types of mental patients.

Mental Deficiency

The following paragraph from the Report is quoted as illustrative of the changed position in which certain progressive authorities are finding themselves since the National Health Service Act came into operation.

> "Throughout the year, the shortage of beds available for the mentally defective (especially children) caused grave concern to the Council. When the institutions for the mentally deficient were transferred to the Minister of Health in July 1948, there were approximately 26 beds per 10,000 of the population available for the reception of mentally deficient persons in the County of London. Under the 'catchment area' schemes introduced by the four Metropolitan Regional Hospital Boards a substantial part of this accommodation was allocated to other local health authorities who had made little or no provision for patients from their areas. As a result, notwithstanding a slight revision of the schemes in the Council's favour during the year, the accommodation available for London cases, based on the proportion of vacancies allotted, was at 31st December 1949, only 17 per 10,000 of the population. Thus the accommodation for London patients has been reduced by approximately one-third and the division of this accommodation among the four Regional Boards imposes further restrictions upon its use."

The position as at December 31st, 1949, was that there were 135 patients awaiting admission to institutions, which included 107 children on the waiting list for the Fountain Hospital, of whom 68 were classed as urgent cases.

In connection with the provision of Occupation Centres for defectives living in the community, a more encouraging picture is given. During 1949, nine new Centres were opened and plans were in hand for two further ones, to complete the programme for accommodation for 550 persons.

The Care of Young Blind Children

This is the title of a pamphlet for parents written by Miss Norah Gibbs, Educational Psychologist to the Sunshine Home Nursery Schools, and published by the National Institute for the Blind.

In simple language and with sensitive understanding it answers the sort of questions which are uppermost in the minds of intelligent parents of blind children, e.g. "Why is Baby blind?"; "Ought we to treat him in a special way from the beginning?"; "Should we keep him at home until he goes to a primary school or should he go to a Sunshine Home Nursery School?"; "What about blind children who are backward?"

Health Visitors, doctors, social workers and others visiting homes in which there is a blind child, will find this pamphlet of immense help and should not fail to procure a copy from the National Institute for the Blind, 224 Great Portland Street, London, W.1, or from the N.A.M.H., 39 Queen Anne Street, W.1. Its very modest price is 7d. post free.

"Residential Accommodation"

It will be remembered that under Part III of the National Assistance Act, 1948, the duty was laid upon Local Authorities to provide "residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them".

Ex-Public Assistance Institutions in which hospital beds predominated, were taken over in the majority of cases by Regional Hospital Boards, but to meet the needs of inmates who could not be described as suffering from any specific "illness", some beds were left for the use of Local Authorities.

An article in the *Lancet* of February 3rd records a survey which was made by Dr. Christine Grant and Dr. Sawle Thomas to ascertain the type of persons for whom "Part III accommodation" was being used at present, and enquiry was made into a total of 909 cases in the care of a county welfare authority.

These persons were divided into six categories:

(1) Able-bodied, some transferred from the hospital side on recovery from temporary illness, some who through age or infirmity were unable to live alone in their own homes, some who were friendless, homeless, and unable to find lodgings, some vagrants. Of this group 27 per cent. were under the age of 60. (Total: 329)

(2) Blind and/or deaf. (33)

(3) Permanently disabled. (36)

(4) Frail ambulants including sufferers from chronic bronchitis, arteriosclerosis, myocarditis or general senility. (52)

(5) Mental defectives, psychopaths and old people with transient or mild psychotic disturbance. (114)

A large number of the residents were judged to be feeble-minded, though they had never been dealt with under the Mental Deficiency Acts, and it is a sombre commentary that although some of them were capable of useful work inside the institution "they were now incapable of fending for themselves in the outside world", partly because of the sheltered life they had so long led. It was thought, however, that a small proportion of this group might still be rehabilitated. Transfer to a mental deficiency institution for care and training was in some cases urgent, but to recommend it as a general policy was, at the present time, realized to be impracticable.

There were 345 patients whom it was judged could only be properly looked after in various types of hospitals, viz. chronic sick (125), M.D. institutions (97), mental hospitals (34), geriatric units (82), epileptic colonies (7). The complete separation, however, of Part III accommodation from hospital services for the chronic sick is deplored.

The need for occupational therapy for residents is urged, for "many of them spend their days sitting around in a state of apathy and indifference to everything that goes on in the outside world, and soon become incapable of rehabilitation", and the provision of night hostels from which those capable of it could go out to daily work, is suggested.

Mental Health and the Prison Service

The current Annual Report of the Commissioners of Prisons (published by H.M. Stationery Office, price 4s.) is packed with interesting information and with important facts which should be known to every public-spirited citizen, and not least to everyone who is concerned with mental health which is, both directly and indirectly, given a considerable amount of attention.

In the chapter on "Health and Hygiene" reference is made to an analysis of the clinical histories and electro-encephalographic recordings of 64 cases of murder, based on a research carried on in conjunction with the Maudsley Hospital. The results of encephalography in 38 cases at Wormwood Scrubbs reported on by Dr. Denis Williams are also noted.

Thirty pages of this chapter—printed as an Appendix—are devoted to an up-to-date report, with historical background, on the psychological treatment of prisoners at Wormwood Scrubbs Prison. Dr. John Mackwood writes of his experience in dealing with deeper analytical cases and of group therapy and appends detailed statistical tables. Dr. Jonathan Gould reports on cases treated by psychotherapy in conjunction with electrical shock treatment, narco-analysis, hypnosis or ether abreaction. This report also is accompanied by detailed statistical tables, but both reports emphasize the need for further research before coming to final conclusions.

To meet the new provisions for psychological examination and treatment necessitated by the Criminal Justice Act, 1948, it is proposed by the Commissioners to employ the following psychological staff: 1 Senior Principal Psychologist,

4 Principal Psychologists, 7 Senior Psychologists, 5 Psychologists, 13 Psychological Assistants (for testing), and 14 Psychiatric Social Workers—to work in allocation centres for Corrective and Borstal training, and in remand and trial prisons.

A further section of the Report which is of particular interest to mental health workers is an Appendix on " Neglectful Mothers " contributed by the Governor of Holloway Prison.

Her report is based on the result of a study made at the Prison during the years 1947-49, of 89 women actually serving sentences for child neglect. In addition 53 relatives were interviewed. The picture that emerges is the familiar one presented in various publications on " problem families ", and the importance of poor intelligence as a factor giving rise to neglect is once more stressed. The element of " irresponsibility " is also noted as well as defective social environment in childhood. But it is pointed out that the neglect and cruelty which brings these mothers into court is, in the great majority of cases, a negative and not a positive thing, and there is as a rule no lack of mother love.

The welfare of the young prisoner is a matter of great concern to the Commissioners, and early in 1949, Lewes Prison was set aside as a separate prison for youths serving sentences of 3 months or over, which has made it possible to provide systematic training designed to attack by " brisk discipline " the " lack of physical and mental skill, illiteracy and poverty of mind " which are the prevalent symptoms of this group.

Some Criminal Statistics

In April 1950, the Prison Commissioners report, the daily average population of prisons and Borstals was 20,421, which is the highest figure recorded for 40 years and nearly double the average for the five years preceding the war. Some of this increase is due to the fact that more prisoners were serving longer sentences, but for the year 1948 there was an increase on the 1947 figures of 5,987 men and of 954 women actually received into prison, although the total number (54,768) includes 1,828 persons committed to prison on remand or for trial and not subsequently sentenced.

The decrease in the number of young offenders convicted of indictable offences between 1945 and 1947 was not maintained, and in 1948 their number increased from 19,331 to 20,268. In addition there were 419 youths and 27 girls received on remand and subsequently discharged on being found not guilty, and 702 youths and 485 girls who, although guilty, were dealt with otherwise than by Borstal or imprisonment.

Of the 2,479 youths sentenced to imprisonment during 1948, 25 were only 16 years old and 221 were 17. Of the 277 girls sentenced, 4 were 16 and 23 were 17. It is considered disquieting that although the imprisonment of young persons fell to about 14 per cent. of the convictions, there was an increase of 836 in the number sent to prison for a first proved offence, and that 1,554 of these sentences were for no longer than 3 months. During 1949, however, due to the operation of the new Criminal Justice Act, the number of sentences fell again.

Staffs of Old People's Homes

The National Old People's Welfare Committee is arranging a second Course of Training for Wardens and Matrons of Old People's Homes to begin in October 1951 and to last for four months. The course will consist of six weeks' theoretical training in London, followed by four weeks' practical training in geriatric units of London hospitals, and six weeks practical training in selected Homes.

Through the generosity of the National Corporation for the Care of Old People, grants can be made where necessary towards the cost of the course. Local Education Authorities are also empowered to assist students with grants both for tuition and maintenance.

There are now over a thousand Homes for Old People in existence and the number is rapidly increasing, so that courses of this type are urgently needed.

Further particulars may be obtained from Miss D. Ramsey, M.B.E., M.A., National Old People's Welfare Committee, 26 Bedford Square, London, W.C.1.

Voting Powers of Hospital Patients

In December 1950, the Ministry of Health issued a circular (HMC.50.108) on this subject which contains a section on patients in mental hospitals and mental deficiency institutions.

It is pointed out that a number of these patients will have their names on the electoral register of their home constituency, which may be accessible to the hospital. In such cases they are entitled to vote if they can do so without detriment to their own or the public's interest, and if they are unable to attend personally at the polling station they should be given the opportunity of applying to be treated as " absent voters " and every help should be given to them in so doing.

These instructions apply, of course, only to mental patients or adult mental defectives who got on to the electoral register before being admitted to hospital.

Educationally Subnormal Children

In answer to a question in Parliament put by Mr. K. P. Thompson (Liverpool), the Minister of Education stated in February that at the beginning of 1950 there were approximately 28,000 children in England and Wales known to require education in special schools for E.S.N. children, and there was provision at the present time for about 15,000.

On the subject of E.S.N. children who were also delinquent, Mr. Thompson elicited from the Home Secretary a statement that their number was not

known but that a high proportion of children in Approved Schools were backward and it was estimated that about one-fifth of those under the age of 15 were so retarded as to need special educational treatment.

In this connection it is interesting to note that a survey of 100 consecutive indictable cases coming before the Bristol Juvenile Court showed that 25 per cent. of the offenders were " dull ", 11 per cent. " borderline subnormal ", 7 per cent. E.S.N. requiring special education, and 2 per cent. mentally defective.

News from Scotland

A Mental Deficiency Exhibit

The Board of Management of " Lennox Castle and Associated Institutions " being a hospital group under the Western Regional Hospital Board for Scotland were granted a stall at the " Modern Homes " Exhibition held in Glasgow in October 1950, on which to display the many varieties of arts and crafts carried out by the patients in Lennox Castle, Waverley Park and Caldwell House Institutions. The object aimed at was to interest employers of labour and the general public, and to demonstrate to them that " mentally handicapped " persons trained and socialized in institutions are capable of accomplishing not only routine jobs of work, but also skilled and often intricate crafts, and so become capable of being employed.

The age of the patients whose work was exhibited ranged from school age upwards, with I.Q. from 35 to 80. The stall was dressed by the members of the staff and everything was displayed in an artistic setting. Here were to be seen lace table centres, pots and pans, Fair Isle garments in fascinating colours, Scout uniforms, delicately-painted china, rubber mats, and children's toys, barbola work, also shoe repairs and brushes and many other and useful exhibits. In such a display there was something to interest everyone. The stall became a centre of attraction, and was always surrounded. People were eager to see and to buy and the children laughed and lingered at the toys. Keen disappointment was shown that the goods were not for sale, but many waited to hear what it was all about. Some had relatives (at some time) in the Institutions and were interested and proud to hear more. One obviously ex-patient waited a long time to catch the eye of the stall-holder to say he had once been resident in Lennox Castle. Although unable to read, he recognized the tickets attached to the goods and proudly said that he was an ex-patient. He was now working outside and doing well. Another woman with a partially blind retarded child was eager to know how the work was accomplished. Doctors, teachers and social workers all showed enthusiasm and interest. People from America, Australia, Africa and New Zealand were thrilled.

The exhibition lasted a month, opening each day from 11 a.m. to 10 p.m. The stall was in charge of members of the Lennox Castle staff under the direction of the Physician Superintendent of the group of hospitals. They were ably assisted by voluntary workers of the Scottish Association for Mental Health. In talking to individuals and little groups every opportunity was taken of explaining the nature of the work and the type of patients by whom it was done. Literature on Mental Health and Mental Deficiency was freely distributed and carried away thoughtfully with all the other literature usually collected at an exhibition, to be read leisurely at home. It is impossible to estimate exactly the number of people who looked and listened, but there were many who previously had no knowledge of the possibilities of the handicapped and were amazed at what they saw and heard. Great tribute was paid by all to the hospital staffs for the infinite patience and understanding shown by them in order to achieve such marvellous results.

It was a great show—great in itself and great in its educational value. There is no doubt that among the thousands who visited it, many went away, not " sadder and wiser men " but " gladder and wiser men ". They were " glad " to think of the care and understanding given to the mentally handicapped and " wiser " as to the benefits to be obtained by institutional training and life, benefits to the patients in increased self-respect and confidence, and benefits to the public in a knowledge that by such training many mental defectives can become useful members of the community.

Practical demonstrations of this kind go far to break down prejudice and misunderstanding.

A New Association

From Aberdeen comes news of the formation of the " Aberdeen and North Eastern Association for Mental Health ", with Professor Millar of the University's Department of Mental Health as Chairman and Dr. Valentine (a lecturer in the Department) as Hon. Secretary. One of its first projects is that of helping to start an Occupation Centre for M.D. children. The Association will, of course, be affiliated to the Scottish Association for Mental Health whose headquarters are in Edinburgh.

A Nursery School Survey

At the instigation of the local Education Committee, a group of Letchworth citizens (including members of the Mental Health Discussion Group) began in the autumn of 1947 a survey for the purpose of finding out the extent of the need for nursery schools and the number of parents who would take advantage of them if they were provided.

A questionnaire was distributed to 5,107 householders; effective replies were received from 1,221. Of the replies received from parents with children of nursery school age, the majority were in favour of nursery schools, to enable the mother to go out to work, for the sake of the child himself or to set the mother free for household tasks. Some interesting suggestions were made, including the need for

part-time nurseries taking children on occasions when mothers needed to be released for outings, shopping, etc.

The Survey disclosed that there were 485 children in Letchworth needing nursery school facilities, in addition to 80 children already provided for and 50 in a Day Nursery. The number of new schools wanted was estimated to be at least six, each providing for 80 children, although a maximum number of 40 was suggested by teachers and nurses in the group.

Attention was drawn in the Report to the enterprise of two members who organized weekly nursery groups to enable mothers to take part in educational activities at their church or at the Settlement. It was felt that local authorities might provide similar centres where children could be left temporarily for two or three hours, and the example of Denmark was cited.

This is an interesting example of voluntary initiative and enterprise and of the type of work which can be successfully carried out by an active and public-spirited group of citizens.

Forthcoming Conferences

News has reached us of the following Conferences:

NATIONAL

Central Council for Health Education. Summer School in Health Education, August 22nd to September 1st, 1951, at King Alfred's College, Winchester. Particulars from the Medical Adviser of the Central Council, Tavistock House, Tavistock Square, London, W.C.1.

National Marriage Guidance Council. Fifth Annual Conference at the Hydro Hotel, Harrogate, May 17th to 21st, 1951. Apply to the General Secretary, 78 Duke Street, London, W.1.

British Social Biology Council. Summer School at Besencon, France, from July 31st to August 14th, 1951. Subject: "The Family: Mother and Child." Apply to the Secretary of the Council, Tavistock House South, Tavistock Square, London, W.C.1.

Standing Conference of Societies Registered for Adoption. Conference at the Hayes, Swanwick, Derbyshire, from June 20th to 23rd, 1951. Apply to the Hon. Secretary, Mr. A. Rampton, Gort Lodge, Petersham, Surrey.

Association of Occupational Therapists. Two-day Conference on Occupational Therapy to be held on June 15th and 16th to be opened by Lord Webb Johnson, President of the Association, held in Hoare Memorial Hall, Church House, Westminster. For brochure apply to: Conference Secretary, Association of Occupational Therapists, 251 Brompton Road, London, S.W.3.

Howard League for Penal Reform. Conference at Wills Hall, Bristol, from September 14th to 21st, 1951. Apply to the Secretary of the League, Parliament Mansions, Abbey Orchard Street, London, S.W.1.

Institute of Welfare. One Day Conference to be held at the Polytechnic, Regent Street, London, W.1, on June 9th. Subject: "The Welfare Officer." Apply to the Conference Secretary of the Institute, 374 City Road, London, E.C.1.

INTERNATIONAL

International Congress on Mental Health to be held in Mexico City from December 11th to 19th, 1951. Particulars from the World Federation for Mental Health, 19 Manchester Street, London, W.1.

International Congress for Psycho-Therapeutics to be held in Leiden, Holland, from September 5th to 8th, 1951. Subject: "The Affective Contact." Particulars from the Dutch Society for Psychotherapeutics, Psychiatric Clinic, State University, Leiden, Holland.

Tenth International Montessori Congress. To be held in London from May 11th to 20th, 1951, presided over by Dr. Montessori who will give several lectures (probably in the evening). For details and full particulars apply: Congress Organizer, Montessori Society, 14 Gordon Square, W.C.1.

New Education Fellowship. International Conference at Bishop Otter College, Chichester, Sussex, from July 31st to August 9th. Its aim is to provide creative experience in small groups. For particulars apply: International Secretary, N.E.F., 1 Park Crescent, London, W.1.

We regret to hear that the *International Conference on Mental Deficiency* which was to have been held in New York in May 1951, has been postponed owing to difficulties created by the present world situation.

Reviews

On Not Being Able to Paint. By Joanna Field. William Heinemann, Ltd. 10s. 6d.

This book appears at a most opportune moment. Free painting is becoming fashionable to-day, and its adoption in mental hospitals, as a part of treatment, requires just the sort of cautious guidance we can draw from Miss Field's work.

It should serve as a warning post in our wish to be in the stream, for she shows clearly what strong primitive forces this free painting and drawing brings to the surface. We should therefore hesitate before setting these things in motion in our patients unless the help necessary to their understanding of them is adequate.

Her book should also serve as an indication to many who have been studying artistic products and the creative impulse that no glib formula can be stated on the basis of a superficial examination, even though of hundreds of free drawings.

Joanna Field gives an answer to those who are constantly criticizing psychoanalysis for lack of integrative functions or any philosophic approach to life. She has for the first time, as far as I know, put into words some of the philosophic implications inherent in psychoanalysis and she should be thanked for doing this.

The study of forty-eight of her own free drawings and her interpretation of them by free association in writing, have led her to important conclusions about the creative impulses; the book is an exciting voyage of discovery on which she takes us as she tries to determine what are the deeper processes involved in being able and in not being able to paint.

The drawings themselves are fascinating. Miss Field's sincere and convincing interpretation of them deepens one's own vision and understanding of free paintings. The problems that emerge and are gradually elucidated are those relating to rhythm and freedom, the place of the will, concentration and contemplative action.

In Part I the author finds herself dealing with such themes as being separate or together, outline and the solid earth, etc.

Part II considers the content of the free drawings with chapter headings of " The Monster Within ", " Disillusion and Hating ", etc.

Part III deals with some of the philosophic discoveries.

This book is the most significant on this subject yet published. Because of my extensive experience of psychotherapy in conjunction with free painting in a large mental hospital I feel specially appreciative of such a book. It should be read by everybody concerned with psychological work.

S.L.Y.

Modern Trends in Paediatrics. Edited by Sir Leonard Parsons, M.D., F.R.S., F.R.C.P. London, Butterworth & Co., Ltd. 1951. Pp. x+ 546+55 index. 55s.

Some readers of this journal may think that Paediatrics is a far cry from Mental Health. This comprehensive survey of the latest work on children's diseases contains twenty-one chapters on a variety of subjects each written by an acknowledged expert from this or other countries.

Dr. Mildred Creak writes on child psychiatry and Dr. R. S. Illingsworth deals with the normal development of the infant. Although the book will provide a useful medical background for doctors working in child guidance, it is of more particular interest to practitioners in the field of mental deficiency. Recent work in this subject covers a wide variety of diseases and causative factors, and from this point of view nearly every chapter is of significance.

Mental deficiency may have a fairly specific connotation from the legal and social aspects, but aetiologically it is almost as wide as medicine itself. With increased research into a subject which has hitherto been relatively neglected we find the formerly clear-cut picture of primary or so-called " simple " amentia becoming more and more complex, and the psychiatrist who wishes to keep pace with the latest developments in mental deficiency may well find what he needs in this survey. For example, Chapter One deals with malformations following rubella and other virus diseases in pregnancy. The physiology of the foetal and neonatal circulation and respiration in Chapter Two and neonatal morbidity in Chapter Three form the basis for any discussion on asphyxia and birth injury as a cause of mental defect. Chapter Four explains the now complex subject of the rhesus factor which is of such importance in relation to kernicterus associated with mental deficiency and deafness. Congenital heart disease is of interest to those who deal with mongols and other defectives who have an increased liability to such malformations. Chapter Eighteen on the endocrine glands refers briefly to cretinism, Nineteen on the lipoidoses covers amaurotic family idiocy and gargoylism, and Twenty refers to oxycephaly.

Enough has been said to show the scope of the book, and it will be evident that it is for the specialist reader. It has been reviewed at some length not because it is likely to be read by many in the mental health world, but because it so conveniently emphasizes the new trends in mental deficiency as well as in paediatrics.

The work has been carefully edited and is well produced, and the illustrations and X-rays are clear and relevant.

L.T.H.

Thomas W. Salmon, Psychiatrist. By Earl D. Bond, M.D. Pp. 237. London, Chapman & Hall. 15s.

Dr. Earl Bond has earned the gratitude of a large number of readers on both sides of the Atlantic by producing this biography of Dr. Salmon. It is an unusually good book, as readable as a novel, dealing with well-selected material and in a very realistic way. It is perhaps natural that Dr. Bond should regard his task almost as the writing of a case history, and that makes it more interesting because one realizes the true humanity and fallibility of this near-genius.

Dr. Salmon is shown to us here as someone whose tremendous drive for better conditions for the mentally sick and for mental hygiene had their origins in some of the early emotional frustrations of his life. We learn how from his early days in the United States Public Health Service he was imbued with the spirit of a reformer and with an emotional interest focused in the main on matters psychiatric. Most of us who knew him, or knew about him, realized the close working relationship that there had been between him and Clifford Beers, but this book presents us with many other fascinating pictures of his work, the campaign for the improvement of conditions on Ellis Island, the starting of the mental hygiene movement and the influence towards mental hygiene concepts which he exercised on the Rockefeller Foundation. These are the highlights of the story up to the war.

During the first World War, Salmon not merely planned the psychiatric provisions for the U.S. Army, but served throughout their campaign in France as the senior psychiatric consultant and administrator in the field, and had a major share after the war in writing the massive Volume X of the U.S. Medical History of the War, which was of such value to us in this country in 1939.

To all who were in psychiatry in the Services during the recent war, the extracts from Salmon's letters and the general story that Dr. Bond tells us of his war experience in Washington and in France will have a familiar ring. The frustrations and difficulties that he experienced then were familiar to many of us in more recent years. Salmon wrote in January, 1918:

> " Things are going well but all the time I have to *fight* to get for the mental cases what they need. Invariably they are overlooked or forgotten in planning new things unless I bring them to attention. What a pleasure it must be to be a surgeon, a sanitarian or an internist and not have to keep making the point that *your* patients are sick people. Sometimes, when I am discouraged, I grow tired of it all and wish I had put the hard work and thought into some enterprise which was popular and in good repute but, most of the time, I realize that this is my life job and I must be satisfied with half what those in other work get (for less effort) for those for whom they are responsible. . . "

When he returned to America after the war he continued his campaigning for the improvement of mental hospitals and for the establishment of what became the Veterans' Administration. He played a large part in encouraging the scientific study of delinquency and in the earliest organization of the child guidance movement. Few people can have had such a record of consistent work and effort, culminating as it did in his Presidency of the American Psychiatric Association, and later in the establishment of the Psychiatric Institute in New York. Those psychiatrists in this country who are considering the academic future of psychiatry should certainly read the " Cinderella Story " which starts on page 180 of this book.

Dr. Salmon's tragic death was a great loss, but his accomplishments and the story of his life are certainly things that will live on. This book is interesting, stimulating and healthily challenging. Everyone who is concerned at all with the development of psychiatry and mental hygiene will find good value here. J.R.R.

Psychological Factors of Peace and War. Edited by T. H. Pear. Published on behalf of the United Nations Association by Hutchinsons, pp. 262. 16s.

This collection of essays is a somewhat heterogeneous one; not only in the nature of its subjects but also in the profundity with which they are dealt. The contributions include an imposing list of professors of psychology and psychiatry and are no doubt writing on subjects which they have studied exhaustively. Professor Dicks' account of some psychological studies of the German character presents concisely and most intelligibly the fruits of many years' research.

Several chapters consist of surveys of recent writing, and experimental work, notably Dr. Eysenck's on War and Aggressiveness and Dr. Himmelweit's on Frustration and Aggression, and these are valuable in themselves, and very readable. On the other hand, the reader will be disappointed with the superficiality of some chapters, which do no more than stir their interest; Professor Cohen's chapter on Women in Peace and War is all too brief, and Dr. Kerr manages to dismiss " personality and attitudes towards warfare " in six pages. The effect of threats on security and the influence of increasing armaments on war are considered by Dr. L. F. Richardson but, apart from holding up the success of Mahatma Gandhi's non-violent technique and some suggestions about intermarriage, the reader is given little idea of any more constructive alternatives. Guide-Lines for Research into International Co-operation are given in some profusion by Dr. G. W. Allport.

As a whole, the book is certainly worth reading, and the ideas discussed will set many more in action. The practical importance of the subject is so obvious as to need no emphasis. R.F.T.

Current Views and Practices in Psychiatric Shock Therapy. By Granville L. Jones, M.D.

This is a pamphlet of 30 pages embodying a great number of questionnaire statistics. It is issued by the Manfred Sakel Foundation. As is well known, Manfred Sakel was the originator of insulin shock therapy. It would appear that his teaching is being ignored or criticized in one way or another, and this questionnaire has been sponsored and supported by the Manfred Sakel Foundation.

On almost every page there is a footnote by Manfred Sakel himself, not to mention the three final pages of the report. The whole pamphlet gives two immediate impressions: (1) that the state of shock therapy in the United States is somewhat confused, even as it is in this country; (2) that Manfred Sakel, like many another pioneer, feels that the "classical insulin shock treatment" as initiated and developed by him, is being displaced chiefly by electric convulsant therapy. This aspect of the monograph is rather disappointing; it is distinctly affective in tone, and one concludes one's reading of the pamphlet with the feeling that the pioneer is more than a little sorry for himself over the process of variations in technique. It is not too much to suggest that more patience should be exercised with regard to the numbers of psychiatrists in the United States who are feeling out for some modification of the treatment, and in so doing are getting results that disappoint Dr. Manfred Sakel.

In spite of this, the document has great merits. For those who enjoy statistics there are many tabulations which will be highly approved of by the experienced psychiatrist. In short, the pamphlet might have been even more useful than it will be in spite of this sort of devaluation of heretical variations of technique. For instance, on page 9 we read, "We feel that intensive psycho-therapy shows promise of alteration in basic personality patterns". It would be interesting to know what proportion of psychiatrists in this country share that view. Incidentally, psychotherapy is referred to in several of the tables, and psychiatrists who have had wide experience in this field will be surprised. It is noteworthy that "institutions vary considerably in the schizophrenic-cyclothymic ratio and there is no doubt that some cases of 'schizophrenia' showing remissions in one hospital would have been called manic-depressive types in another". One begins to wonder what would have been the statistical results if a team of experienced workers in this field had been induced to play the Twenty Questions game over this well-thrashed-out subject. Here, for instance, is one of Manfred Sakel's annotations: "Skeletal and diabetic contra-indications are relevant only in shock treatment which employs convulsion exclusively."

The whole monograph gives the impression that insulin is being less and less tried, both for convulsive therapy and for so-called modified treatment. Thus, in one table alone, we note that electricity is used in 15 per cent. of cases—insulin in 16 per cent. Again, the treatment of psycho-neuroses is in some hospitals based upon insulin and in others on electricity. Another large group (21 per cent.) stated categorically they did not use shock for psycho-neuroses. "It is clear, then, that a larger group of all answering are more dubious as to the value of shock in psycho-neuroses than in schizophrenia or manic-depressive, that if shock is used, electricity is preferred, and that insulin is likely to be used in 'tonic' or sub-shock dosages."

One lays down the monograph with the feeling that it is well worth while for a psychiatrist to have such important figures at hand to check up on his own experience. On page 27 we have this rather frustrating paragraph: "A majority of hospitals feel that insulin shock is better for schizophrenia but many prefer to try electro-shock first. The consensus is that electro-shock is superior in manic-depressive psychosis. A majority of hospitals appear to doubt the value of shock in psycho-neurosis, but if used, electricity or sub-shock insulin seems to be preferable. The opinion appears to be almost unanimous that electro-shock is the most effective therapy for involutional melancholia."

In his final summing up Dr. Manfred Sakel repeatedly refers to the classical insulin shock treatment for schizophrenia. He has obvious difficulty in adjusting himself to views put forward by psychiatrists who have introduced variations in their technique and have good results to show for them.

In brief, I would urge psychiatrists, both young and old, to procure and preserve this pamphlet and to compare it constantly with their own results. Only so can the psychiatric field be adequately explored by those who have perhaps got into a rut or have felt frustration and disillusionment in physical means of helping their patients to recover, if it may be, from their psychosis.

H.C.M.

An Introduction to Personality Study. By Raymond B. Cattell, Research Professor in Psychology, University of Illinois. Hutchinsons University Library. 7s. 6d.

In the last fifty years there have been a large number of books written on Psychology, and especially on personality. A reader who has behind him at least some of the standard text-books finds his way in the maze of psychological literature comparatively more easily than a student who approaches the subject for the first time. The latter may feel embarrassed by the thousands of volumes that lie between him and the secrets of the psychological science. For an intelligent student, Professor Cattell's book *An Introduction to Personality Study* not only removes this embarrassment but also safeguards him from the disappointment which usually follows extensive reading not rewarded by the acquisition of certain factual knowledge.

Professor Cattell's book is a compact treatment

of personality in its most fundamental aspects. Being so compact it naturally can present only summaries and generalizations. The author purposefully puts aside the speculative part of the subject and deals chiefly with what can be measured and verified. The author gives statistical evidence for his statements or, in the absence of such evidence, indicates the way in which it could be obtained.

No doubt in this respect he wants to be a thorough going behaviourist and determinist. This position, however narrow it may appear to philosophically minded psychologists—for it may conflict with the notion of free will, moral action etc.—is perhaps the only one which renders some practical advantages. These advantages cannot be secured by metaphysical speculations nor by biased personal judgments. If the progress of psychology is to be estimated by the number of discovered facts and empirical laws, the scientific research ought to be the only legitimate method in use. It is encouraging to find that Professor Cattell's outstanding ability once more suggests this method. Through statistical analysis, chiefly through correlations and factor analysis, he hopes the description of personality can be made more exact and the measurement of personality not at all impossible.

The reader may find a quick introduction into various aspects of the subject, the most important being the relative influence of heredity and environment, the normal and abnormal development, the body-mind relation and the adjustment to the social pattern.

The reviewer recommends the book to the beginners who want to have a quick grasp of the subject and also to those advanced students who have found psychological speculation unproductive and who consequently may feel more interested in the factual study.

O.P.

Jealousy in Children. By Edmund Ziman, M.D. Gollancz. 12s. 6d.

This American book, recently made available in Britain, is a particularly effective guide for parents on a topic widely regarded as a major source of difficulty in children. Beginning with the premise that the word jealousy " has become associated with an extremely unpleasant and destructive emotional disturbance which we do not like to admit may be present in our children ", Dr. Ziman shows clearly that jealousy is a perfectly normal reaction and that it is the poor parental handling of jealousy or the failure to recognize it—not the feeling itself—which causes many unhappy experiences. He defines a jealous child simply as one who wants something someone else has, with the " something " being basically love, understanding and protection.

After a discussion of guilt feelings in parents, the author then takes up the question of jealousy in various situations, such as with an only child, the second child of three, twins, when children's ages are close together and when they are far apart. There is also an exceptionally well done section on step-parents and step-children and the troubles peculiar to them. The book is easily readable and non-technical throughout, with an abundance of very descriptive case material.

Jealousy in Children should prove to be of special value to workers in child guidance and could easily be recommended by them to many of the parents they are trying to help. Those parents who read it should then be much better equipped to recognize signs of jealousy in their children and to deal with this emotion as normal and treatable rather than as wicked and hopeless.

D.L.R.J.

Children with Mental and Physical Handicaps. By J. E. Wallace Wallin, Ph.D. Published by Staples Press, Ltd., London. 42s.

Mental defect has become in the public mind too much associated with idiocy and imbecility. Dr. Wallace Wallin, who is Professor of Clinical Psychology in Uppsala College, has very properly pointed out that the mentally defective group is only a small part of the problem of the intellectually sub-normal in the educational sphere. He says:

> " The problem of the backward or dull child is, educationally considered, far more important than that of the mental defective, for dullards are much more numerous and much more promising. The backward child has sufficient capacity, not only to make his way in the world socially and vocationally, but also to attain considerable success in many trades, occupations, and vocations in which he possesses special aptitude. He will attain such success if he is given proper vocational training in school in correlation with the literary work, provided that he is not handicapped by hampering temperamental, emotional, volitional, and moral abnormalities. Many dullards often possess traits that may compensate for their intellectual dullness—such as industry, persistence, enthusiasm, ambition, and working energy—and that may enable them to achieve greater success in many walks of life than some intellectuals who lack motivation and who detest work. The backward child, then, is potentially capable of self-maintenance, self-management, and self-determination."

This is in line with the more enlightened attitudes of the progressive workers in the field of mental deficiency, and the value of the book is in its positive and encouraging approach to the subject. An interesting chapter on the educability of the backward pupil is full of suggestions that might well be applied in this country.

Dr. Wallin surveys the recent work on glutamic acid, vitamin B_2 and benzadrine in the attempt to alter the mental state of the defective. He quite rightly points out that there is little evidence to justify the optimistic expectation that mental defectives can be restored through benzadrine therapy. His cautious attitude is also applied to

the research in the use of glutamic acid, and he quite rightly says that much more extensive research is needed before conclusions can be drawn. He is less happy in the sections devoted to physical disabilities, and perhaps it would have been better if he had not attempted to cover these. A.T.

Problem Families in Bristol. By R. C. Wofinden, M.D., D.P.H. The Eugenics Society and Cassell & Co., Ltd. 2s. 6d.

This extremely modest pamphlet contains more facts and stimulating suggestions than many portentous volumes, and is to be very heartily recommended.

The project was undertaken at the request of the Eugenics Society, to study methods of research into problem families and in so doing has provided a useful survey of the position in Bristol. The degree of association of these with housing conditions, size of family, child neglect, illegitimacy, delinquency and physical ill health of the mother, is noted. A significant finding is that the intelligence of over 60 per cent. of fathers and over 75 per cent. of mothers appeared to be subnormal—and the picture of squalor, apathy and unadaptibility in the families emphasizes this fact.

Recommendations are made for a single responsible authority but for a wide committee representative of various interests to be set up—for opportunities of convalescence for mothers, and for rehabilitation centres and home advisers, the training at the former to be supplemented by the latter. The only criticism is that there is perhaps too little awareness of the skilled psychiatric advice which will be needed by both these.

This pilot survey now deserves to be followed by a reconnaissance in force. R.F.T.

A Group of Juniors. By Frances Tustin. Heinemann. 6s.

This slim book, with its attractive dust cover, presents from the first glance an air of freshness and youth, the very essence of the juniors' attitude which it portrays.

The first half of the book consists of a "Diary"—records of some of the conversations, drawings and activities of a group of twelve children in a progressive co-educational boarding school. The author made " no selection whatever on any grounds " of the " random samples " of activities which she found it " easy and convenient " to record.

In the second half of the book, the author comments on the recorded material and suggests how far the attitudes expressed by the children can be considered as characteristic of juniors in general and how far they are particular to this group.

She ends with a brief chapter on group fantasy.

The book reads easily. The author has a light, friendly and unobtrusive manner. She lets her material speak for itself practically throughout. Partly because of the absence of selectivity, however, the argument is less pointed than it might have been. Also, the method adopted of separating the Diary and the comments on it, leads to repetition which might have been avoided with a different plan.

These criticisms, however, are not major ones. The book is well worth reading. It is a contribution to the literature on junior-age children not least indirectly in its portrayal of the author's attitude when in action with the children. The insight into and sensitivity towards the meaning of children's play and fantasy is rare, especially when combined with a total absence of either sentimentality or unhealthy introversion.

H.C.

Borstal. A Critical Survey. By Winifred A. Elkin and the Rev. D. B. Kittermaster, M.C., M.A. Howard League for Penal Reform. 2s. 6d.

This pamphlet of forty-two pages, with four well-chosen photographs, has been skilfully planned. In the " critical survey " itself the criticism grows naturally out of the description, and for this reason, and because it is sober and balanced, carries the more conviction. In contrast, the last ten pages are given to the freely expressed opinions of a writer who, in the course of his varied experience, served as chaplain at Rochester Borstal. This adds warmth and immediacy which would be out of place in the admirably clear description of the survey itself, dealing with such subjects as " Borstal System and Law ", " Borstal and Approved School Absconders ", " After-Care ", as well as giving a short account of life in the various institutions and the problems involved.

Both parts of the pamphlet emphasize the crucial importance of the character of Governor and House Masters and the value of the sense of vocation commonly found among them. No mention is made of the need of special training, or at least of ensuring that the Borstal staff is in a position to draw upon such insight as psychology and psychiatry have to offer into the problems of individuals and of how to help them on the basis of a personal relationship. Mr. Kittermaster is certainly fully alive to the problems and makes a plea for differentiated treatment. He urges that it should be implanted in the boy's mind from the first " that he is not a naughty boy or a wicked criminal, but a sick man ", a condition lacking in glamour. He recognizes, too, the futility of committing to Borstal young men convicted of sex offences and the need in such cases of the services of the medical psychologist.

The few pages devoted to " Borstal for Girls " are of special importance, since the subject has hitherto been almost entirely neglected in the literature of delinquency. Fortunately, it is now possible to compare this part of the pamphlet with the findings of Dr. P. Epps, whose valuable article, " A Preliminary Survey of 300 Female Delinquents in Borstal Institutions ", appeared in this year's January number of the *British Journal of Delinquency*. M.A.

The Inner World of Man. By Frances Wickes. Methuen. 21s.

This book, first published in the United States in 1939, has now been published in Great Britain. It is very readable and delightfully illustrated with 29 drawings and paintings.

Mrs. Wickes is a Jungian analyst and her book provides an excellent introduction to analytical psychology and is based on case material collected over years of practice. In the first section Jungian concepts are explained; the second section deals with case histories, and the illustrations come at the end.

Whether or not the reader adheres entirely to Jungian theory, there is much in this book which is inspiring and helpful. In discussing the Self, for instance, Mrs. Wickes writes:

> "The Self is ever created and creating. As we ourselves become newly created, the energy flowing through us seeks an outlet in creation. It may be in new life experience or it may seek a concrete form."

and again:

> "So, at each step, we find the necessity for accepting the living reality of our own individual life."

This is a beautifully written book and well worth reading for pleasure, quite apart from its scientific value.

C.H.-S.

Reading Ability. Some Suggestions for Helping the Backward. Ministry of Education Pamphlet No. 18. H.M. Stationery Office. 1s. 6d.

In 1947, a small committee of experts was set up by the Ministry of Education to investigate the reading ability of children and young people in England and Wales. They have now published their findings in this pamphlet.

The Committee limited itself to one aspect of reading—the ability to read silently with comprehension. A new test to assess this ability was constructed by Dr. A. F. Watts and Professor P. E. Vernon and given to 2,800 pupils between 10 and 11 years, and to 3,400 pupils of 15. It was also given to 3,000 men and women recruits to the Forces to discover if there was any evidence that skill in reading fades after pupils leave school.

Definition of illiteracy was based on attainments of average children in 1938. A person having a 1938 reading age of less than 7 years was deemed illiterate; semi-literacy was taken as a reading age of between 7 and 9 years. 1·4 per cent. of pupils of 15 were illiterate, 4·3 per cent. semi-literate. If semi-literacy had been attained there was no fading of reading ability in adult life.

The pamphlet expressly disclaims being an official textbook on the teaching of reading, but it goes to the heart of the matter in stressing that the whole work of the school should relate to the reading attainments of pupils, or all other subjects will be beyond their powers. Reading is one aspect of the ability to handle language and must be linked up with all the interests of the child so that the written word is accepted as a natural and necessary accompaniment of living.

The formal teaching of reading must be tuned to the child's development, and a closer link established between the methods of the infants' and junior schools. This individual approach is paramount in teaching the older backward reader. His interests must be linked with his reading, and his confidence built up by easy early success and the encouragement of the teacher.

The new problem of the illiterate adult, both in army and civilian life, is also discussed. Here, also, early success and personal progress is vital. Much research remains to be done, but the Committee feels that the gain to each person rescued from illiteracy is so great that much labour can legitimately be expended on the whole problem.

I.M.S.

Health and Human Relations in Germany. Report issued by Josiah Macey Jr. Foundation, U.S.A. Obtainable in U.K. from H. K. Lewis & Co. 5s.

This book reports the deliberations of a conference held in Princeton in June 1950, as a result of a suggestion by Dr. J. R. Rees, at which American Social Scientists and Psychiatrists and representatives of American Government agencies with recent professional experience in the Western Zones, met to consider problems of German rehabilitation in these Zones. The conference was attended by two Englishmen, one Frenchman and four Germans.

The conference threw its net wide, and ranged over such problems as "How have the German people come to be as they are?"—the need for improvement in German services of Psychiatry, Social Science and Education, the integration of German culture within itself and into European and world cultures, and "What can be done to encourage people throughout the world to face the fundamental issue in all human relations—the prevalence of hate and the great need of love."

This being so, it is hardly surprising that the recommendations produced by the conference add nothing of startling originality to the study of the German problem. The value of the conference clearly lay—as its organizers meant that it should—in the pooling of ideas and impressions by experts who had previously laboured in ignorance of work done in related fields.

It is encouraging to know that a similar conference may be held in Germany in the spring of 1951, in which German professional workers will be asked to participate.

M.F.A.

The Indiscretions of a Magistrate. By Basil Henriques. London, George Harrap & Co. Ltd., 1950. Pp. 185. 8s. 6d.

This book is a companion to the author's *Indiscretions of a Warden*. It serves as a useful guide in human terms to the work and procedure of the London Juvenile Courts, and is easily read by a person who has no previous knowledge of this field.

Mr. Henriques, who has been a magistrate of the East London Juvenile Court since 1924, may be congratulated that it is his purpose to show that there is no short cut remedy to the problem of delinquency. He says of himself that in Court he does his best to distinguish between the mentally sick and the mischievous and to treat each according to his needs, and he has many interesting comments and suggestions to make. For example, he mentions the success of the camps held by the Toynbee probation officers for their probationers. By the end of a week's camp the boys " have shown their own peculiar characteristics and the probation officer is in a far better position to know how to deal with the boy, and the boy also knows the qualities of the probation officer and the amount of confidence he feels he can give to him."

With regard to children who persistently abscond, he suggests that they are in need of psychiatric treatment, and that it is unfair to them not to make it difficult to escape from school. He therefore proposes a " closed house " as part of the ordinary approved school. Children should graduate from this to the open school once they have remained in the place long enough for the staff to win their trust and confidence.

The most serious criticism, however, must be levelled against certain prejudices of the author which pervade the book, and amount to some distortions of fact. In listing the progressive schools as one of the main causes of delinquency, he shows an extraordinary misunderstanding of their aims and methods. In fact, has any child who has spent all his life in a progressive school yet been found in a Juvenile Court ? Mr. Henriques seems to imagine that there is no alternative between an authoritarian regime where discipline is imposed by the adult, and a liberty " to do what you like " irrespective of the consequences.

The failing of many an anti-social child is that he lacks self-discipline. As soon as adult-maintained controls are removed he falls to pieces. Craftwork, that Mr. Henriques derides, is one means of developing self-discipline—for this is provided in the materials used. It becomes self-evident to a child that in order to make an object, say in woodwork, he must use his muscles and master certain techniques. He learns to do the unpleasant parts of a task because he himself understands their necessity, not because he has been forced to submit into doing what he does not like for the sake of satisfying an external code.

Freedom is a quality that demands knowledge and willpower, whereas liberty is a state of existence which may be granted by one person to another. The progressive schools have grasped this distinction; they give children responsibility for their actions by giving them opportunities and making them take consequences. The alternative to a " regime of no discipline " is one of persuasive discipline, in which children grow to full stature, able to control themselves, to work for its own sake, and to manage the affairs of their immediate community.

A.W.

50,000 Outside the Law. An Examination of the Treatment of those Certified as Mental Defectives. National Council for Civil Liberties, 46 Westbourne Grove, London, W.2. 1s. 3d.

This pamphlet calls attention, in most lurid terms, to alleged abuses, present or possible, in the certification and detention of people as mental defectives. These abuses, it is said, consist in certification by inexperienced officers, in the retention of defectives at work at unfair rates of pay, and in inadequate use of the safeguards provided by law. The report includes almost incredible accounts of posses of police officers descending on patients at dead of night to take them back to institutions; there are also acid criticisms and illustrations of the impersonal style of answers provided by the Ministry of Health which do not deign to enter into the detail desired by their correspondents.

All these criticisms are, if true, extremely serious, and there is only one proper answer which has already, it is understood, been given by the Board of Control, that information given about any particular case will at once be investigated and obviously this investigation will be certainly undertaken. It is also possible that the Ministry of Health may consider adopting a somewhat more human phraseology, as is now used by other authorities with some success. No doubt the National Council for Civil Liberties is quite right to raise an outcry where it believes abuses have occurred. Nevertheless, it is to be questioned whether they have not got the whole matter in any case somewhat out of proportion; for if such episodes as they quote do indeed occur, which is as yet not proved, then they must be extremely few in number compared with the opposite side of the picture, i.e. the very serious number of urgent cases awaiting institutional care. There can be few Members of Parliament or people in public life, who have not been approached by some unfortunate parent or guardian about the date of a defective's admission to an institution. This delay in admission is, of course, largely due to nursing shortage, and it will be unfortunate if the cases quoted by the pamphlet have the result which certainly was not intended—of further discouraging nursing recruits, and thereby making the position far worse than it was before.

R.F.T.

Correspondence

THE FOURTH MEMBER OF THE CHILD GUIDANCE TEAM

DEAR SIR,—The team of Child Guidance Workers is usually described as consisting of three members: the psychiatrist, psychologist, and psychiatric social worker. There is, however, a fourth member whose help is indispensable for an efficient function of a Child Guidance Clinic, but whose importance for the work is not yet fully recognized: the clinic secretary.

The administrative side of Child Guidance work is very important, and considerable technical skill in shorthand, typing, filing and statistical registration is required for it. However, office work is not all a secretary has to do, but only one aspect of the work.

The clinic secretary also acts as appointments officer. Interest in and understanding for the problems of the patients are necessary to do this work successfully. As appointments officer the clinic secretary will often be the first person of the team to come in contact with parents and children; the manner in which she introduces them to the clinic and deals with them can sometimes play a noticeable role in the treatment. As a matter of fact, the way in which she discusses and explains questions which are frequently asked of her in the waiting room or the office amount sometimes to psychotherapeutic assistance. In a Child Guidance Clinic, as in any psychotherapeutic clinic, every word which is said to patients can have therapeutic significance as psychotherapy in these clinics is mainly verbally conveyed help.

Special personal qualities are thus required from the clinic secretary far exceeding technical efficiency in office work. The notes written by the other members of the staff on the patients and many reports and letters contain often highly intimate and confidential material. Personal maturity and absolute reliability is therefore needed from the secretary. Tact in dealing with suffering and often difficult persons, adults and children, is required, as well as personal keenness to help them.

The requirements for the work of clinic secretaries of Child Guidance Clinics are as high as can be in any medical clinic. Yet the status of this work as regards salary, promotion and holiday arrangements especially for the younger age groups is still considerably lower than that at many other clinics. This threatens to lower the qualifications of the candidates applying for these posts, and therefore the efficiency of the whole Child Guidance work.

May I point out that it is in the interest of the Child Guidance Service to reconsider and raise the status of the fourth member of the team: the Clinic Secretary.

Yours, etc.,

Child Guidance Clinic,
Bexleyheath, Kent.

E. WELLISCH.

THE PLACE OF THE MENTALLY HANDICAPPED CHILD IN SOCIETY

DEAR SIR,—There has grown up a body of law in this country with regard to the care and education of mentally handicapped children based upon the assumption that there are three categories of children: normal, educationally subnormal, and mentally defective.

All who have had anything to do with the categories regarded as subnormal will know from experience that the position is far from satisfactory. The fact that many thousands of children under this system are left " out in the cold " may at various times be attributed to the war, to pre-war neglect, to lack of building and staffing facilities and so on. But the underlying cause would appear to be the attitude that these children are not worth spending money on because they are " ineducable " and will in any case not be able to " plough back " into the communal coffer what has been spent on them.

The purpose of this letter is to submit a case for re-grouping the children on more realistic lines. The horizontal division between the " normal " and the " subnormal " ignores more important *vertical* divisions. There are three categories of people—normal, physically handicapped and psychologically sick. Within these divisions, people may be of high, medium and low intelligence, but their actual performance is determined not just by immutable intelligence quotients, but by the accidental or environmental influences of their physical and mental health.

Visiting Special Schools, Occupation Centres and Institutions, one can see that there are many children who do not fit tidily into the environment. There is a great need for residential hostels, for instance, for children who are so severely maladjusted or deranged that they are unable to take advantage even of Occupation Centres inside Institutions (and even though their intelligence might be of Special School standard) and have to be kept with adult deranged patients.

At the same time, those children who are normal in their social responses and well able to live with

their families and play games with ordinary children should not be segregated in residential Homes and Schools, but should be enabled to attend Special Classes and Centres attached to ordinary schools.

Children who are physically handicapped by cerebral palsy, etc., or by partial sight or hearing, should have medical, surgical and educational treatment for those defects, irrespective of the alleged level of intelligence. Special Schools—residential where necessary—should be provided for all grades of the physically handicapped, because this kind of defect produces a social maladjustment and mental backwardness which may obscure the innate abilities of the child.

It is unfortunate that the Census Form recently issued does not provide for the collection of specific information about handicapped persons. The Ministry of Health's Advisory Council for the Welfare of the Handicapped has issued Survey Forms which may be distributed through County Council Welfare Committees, but it appears that not many counties are co-operating wholeheartedly in this enterprise. It is still impossible to state definitely how many handicapped persons, including children under 16, there are in the community, and until this information is available, it is a simple matter for a local authority to postpone adequate provision on the grounds that there is "so little demand".

In certain parts of the United States, it is laid down that every school district with a child population of 900 or more *must* provide Special Schools for the handicapped children in its area. This is presumably based upon ascertainment figures which are taken as an average for the community. In this country the rate of ascertainment is still a matter for local whim and fancy, and is probably in no area a really accurate measure of the need for special provision.

There is, in addition, an artificial dividing line between what is called "education" and what is called "training". Dictionary definitions of education include training, even of animals, and visits to Nursery Schools provided for normal children under the Ministry of Education provide convincing proof that reading, writing, and mathematics can be omitted from the curriculum without destroying the essential educational quality of the training. Different types of education should exist in the nursery and primary stages, as they do now in the secondary stage, side by side and with "parity of esteem".

It seems clear that the present set-up is based upon an old-fashioned idea that it is permissible to ignore and neglect a substantial portion of the population if no useful purpose, measured in terms of pounds, shillings and pence, can be found for them. Such a concept is out of place in this day and age, and we should begin to reconsider existing provision, or lack of it, for our handicapped brothers and sisters, in the light of modern thought about the purpose of life and communal responsibility.

Yours, etc.,
JUDY FRYD.

8 Westfield Avenue,
Harpenden, Herts.

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